

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

04 - 15

2. STATE:

Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

October 1, 2004

TO: REGIONAL ADMINISTRATOR  
HEALTH FINANCING ADMINISTRATION  
DEPARTMENT OF HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

12 CFR 440.225

7. FEDERAL BUDGET IMPACT:

a. FFY 05 \$ 1,300,000

b. FFY 06 \$ 1,300,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement to Attachment 3.1-A, pages 16 and 17

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Supplement to Attachment 3.1-A, pages 16 and 17

10. SUBJECT OF AMENDMENT:

Optional Services

11. GOVERNOR'S REVIEW (Check One):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:  
Paul Reinhart, Director  
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:

*Paul Reinhart*

13. TYPED NAME:

Paul Reinhart

14. TITLE:

Director, Medical Services Administration

15. DATE SUBMITTED:

*November 17, 2004*

16. RETURN TO:

Medical Services Administration  
Program/Eligibility Policy Division - Federal Liaison Unit  
Capitol Commons Center - 7<sup>th</sup> Floor  
400 South Pine  
Lansing, Michigan 48933

Attn: Nancy Bishop

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

11/18/04

18. DATE APPROVED:

*2/3/05*

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

*Cheryl A. Harris*

21. TYPE NAME:

Cheryl A. Harris

22. TITLE:

Associate Regional Administrator  
Division of Medicaid and Children's Health

23. REMARKS:

**RECEIVED**

NOV 18 2004

DMCH - MI/MN/WI

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State: MICHIGAN**

***Amount, Duration and Scope of Medical and Remedial Care  
Services Provided to the Categorically and Medically Needy***

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**5. Physician Services (continued)**

- g. **Laboratory services** performed in the physician's office are limited to those determined to be reasonable and appropriate for that site. Other laboratory services are covered upon determination by the department to be medically necessary for the setting and specific patient.
- h. **Physical therapy services** as defined in 1.a of this attachment.

**6. Medical Care Furnished by Practitioners within the Scope of their Practice as Defined by State Law**

No payment will be made for services of staff in residence or medical staff functioning in an administrative capacity for a hospital or nursing care facility, including practitioner-owners. In relation to outpatient services, practitioner fees for covered services are payable only when such payment does not duplicate payment to the facility.

**a. Podiatry Services:**

Covered services include those falling within the scope of practice under state law, as limited by the department, necessary to diagnose and/or treat illness, injury, the prevention of disability, or services provided recipients suffering from specific systemic diseases for which self-treatment would be hazardous.

**b. Optometry Services:**

Covered services include:

- a. Complete eye examination if medically necessary. Examinations which exceed a frequency of once every two years, must be documented as medically necessary.
- b. The following corrective lenses; some of which require prior authorization:
  - i. single vision or multi-focal eyeglasses;
  - ii. cataract lenses;
  - iii. contact lenses, evaluations and services
  - iv. special lenses, as specified by the department.

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TN NO.: 04-15

Approval Date: Feb 10 2005

Effective Date: 10/01/2004

Supersedes

TN No.: 03-11

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State: MICHIGAN**

***Amount, Duration and Scope of Medical and Remedial Care  
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**6. Medical Care Furnished by Practitioners within the Scope of their Practice as Defined by State Law (continued)**

**b. Optometry Services (continued):**

- 3) Orthoptic and low vision evaluations, services and aids (which must be prior authorized).

Requirements relative to the provision of eyeglasses are described in item 12.d of this attachment.

**c. Chiropractor Services:**

Chiropractic x-rays, as limited by the department, are covered for all age groups. Spinal manipulations are covered for all age groups.

**d. Other Practitioner Services:**

**~ Oral Surgery**

Services provided by a licensed oral surgeon are covered as follows:

1. for hospital inpatients under the conditions specified in item 1.c;
2. for treatment provided on a hospital outpatient basis or, in the office for treatment of conditions specified in item 1.c.1) a).

**~ Certified Nurse Anesthetists (CRNAs)**

Services provided by registered nurses certified by the council on Certification of Nurse Anesthetists or re-certified by the Council on Re-certification of Nurse Anesthetists are covered. Services are limited to those provided on an inpatient or outpatient basis and reimbursement is directed through the employing or contracting hospital.

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